

If doctors all went on salary, cost to public funds would increase by 97%

By M.A. Baltzan, M.D., F.R.C.P.[C]

With continuing public discussion on the costs of providing health care, coupled with the considerable attention directed at physicians' incomes, CMAJ believes Dr. Baltzan's informed comments on method of payment to be particularly timely. His article is followed by one by a Montreal consultant which discusses further aspects of public health care policy.

In its following issues, CMAJ will publish in series the text of the special report to the Ontario Medical Association by Edward Pickering. Mr. Pickering, a retired industrialist, was commissioned by the OMA to make an independent study of the role of the profession and its relations with the public and government. The Pickering report has been widely welcomed as a valid and perceptive study and many of its recommendations have been accepted, within and outside Ontario.

To act in rational economic self-interest, a seller of labour would be inclined to offer his services on a time basis, while a buyer of labour would seek to obtain these services on the basis of product. For example, if you wish to have a brick fence built, your economic self-interest is best served by paying your bricklayer on a rate per brick. On the other hand, if you are the bricklayer, your economic self-interest would lead you to contract to build the fence on a time rate. If this hypothesis is correct, the attitudes of the medical profession and some representatives of the public with respect to the payment of physicians are confusing. If both were acting on economic self-interest, the physicians would be demanding payment per unit of time (salary) and the public demanding payment per product (fee for service). In actual fact, the opposite is true: the profession largely demands fee for service and the public representatives salary. Is everybody truly confused?

The test would be to compare physi-

cians' incomes and cost to the public when physicians are paid on salary and fee for service bases. The Department of National Health and Welfare has indicated the mean income for all active fee practising physicians for the year 1970 was \$34,360.

The physician as employee

Let us see what it might be on a salary basis. The physician, now an employee, would enjoy the privileges and prerogatives assigned to other skilled tradesmen paid by the hour. An eight-hour day, five-day week might be acceptable. Because of the nature of the work, like school teachers, control tower operators and airline pilots, the physician could hold out for a much shorter week. Overtime would be paid at a time and half rate, although it is conceivable that a contract might be entered for some of the overtime at double or triple time — an established practice in industry. He/she would be prepared to answer hospital and housecalls after hours but for our doctor like the callback time for fellow skilled tradesmen the minimum time would be the accepted four hours. Salaried physicians would certainly be entitled to at least four weeks vacation with pay. Then one could negotiate stand-by time in a contract, but at first lack of skill in negotiation might preclude bargaining. However, one would receive the customary fringe benefits which now amount to at least 14% and in many cases 17% — let us say 14%. In future years increased income without additional work might result from negotiating study time period and travel expenses. Let us assume that these items are not in the original contract.

How much money would the doctor make under these conditions? Two other bits of information are needed before we can perform the simple

mathematics needed to calculate net income:

- How many callbacks are there? Let us assume: callbacks two night per week and only one callback on weekends.

- How much should the physician be paid per hour? Current hourly rates for skilled and non-skilled workers would indicate a rate of \$20/hr. might be quite reasonable. Again, doctors are new at this business and are probably incompetent negotiators; they might well settle for only \$12/hr. What then is the doctor's annual income? It is \$40,766 per year — on minimum conditions, no standby, no double time, no triple time, only 14% fringe benefits and only \$12/hr. Doctors would be more than 18% better off on salary than they are today in Canada on fee for service.

Would this mean an 18% increase in the cost of physician services to the public? No. Provided that the state could now keep the overhead expense as low as the individual doctor could when it was his personal financial responsibility, the 18% increment would only be on the doctor's net portion and not on the 30% overhead portion. Therefore the gross income of doctors, as opposed to the net income, would go up by only 12.5%.

However the matter probably would not end here. Following standard negotiating practices, the contract would probably specify the number of patients the doctor should see during regular hours. Given the public's desire to spend sufficient time with the physician, the contract might require 30 min./patient. If this were the case, allowing for patient movement, dictation and coffee breaks, the physician would see approximately 3500 patients/yr. in regular hours. The Saskatchewan doctor now sees 7000 patients/yr., probably 6000 of these in regular

working hours. Therefore we would need at least 75% more doctors who would each require the same amount of money in net income and expense as the original group of doctors. Physician expense to the public would go up 12.5% for the original doctors so the new doctors would receive 75% and 112.5%. Thus in comparison with the base figures the increment for the new doctors would be 84.4%, the increment for the old doctors would be 12.5% and the actual increase in the cost of physician services to the public would be the sum of these two or

97%. Thus the net effect of changing to a salary system is to increase the cost to the public of physician services by 97% and to increase the net income of physicians by over 18%.

Self-interest and fee for service

Everybody is confused. Whether unwittingly or not, doctors are not acting in their own self-interest by favouring fee for service. Likewise those members of the public who demand salaries for physicians are misguided and do

not act in their own economic self-interest. If one takes a more sophisticated approach, it is possible that doctors are acting in enlightened self-interest by favouring the fee for service system though it may forfeit some income. In the long run the medical profession can only prosper if the public prospers, and fee for service clearly favours this prosperity more than salary does. Finally the public, in continuing to support fee for service despite the hitherto obvious arguments against same, has exhibited an intuitive intelligence which must be respected.

Politicians see health care as an exceptional springboard

By André D. Fortas, M.D.

In this article, a translation of one published originally in the Montreal newspaper *Le Devoir*, Dr. Fortas discusses some implications of the entry of government into provision of health care. Dr. Fortas graduated in Haiti, then went to the University of Toulouse to study international development.

Each year when the health insurance board submits its annual report, the media and a section of the public seem to suddenly discover that doctors' incomes are astronomical, and seize on that discovery as sole cause for the uncontrollable costs of health programs.

This is a convenient attitude because it satisfies, for the moment, a certain feeling of social frustration in a society where everyone would like access to a relatively high standard of living and to consumer goods put within reach of human desire by persistent advertising. But in this society everyone doesn't have the financial means necessary to obtain them. On the other hand, a scapegoat — the medical profession — can bear the responsibility for the excesses which each citizen decries but accepts. Doctors are becoming more and more a cog which has very little control over the main wheel.

Easy clichés

It is high time for all of us to shoulder responsibilities, examine consciences and judge the present situation

according to the facts, before giving free rein to impulsive statements and easy clichés.

Let us recall briefly that health care services have undergone an evolution; the doctor has progressed from the status of priest, sorcerer or magician to that of scientist (with heavily subjective connotations). In plain language, what makes a good doctor in the eyes of the public is not primarily academic qualifications, but human qualities, as the patients see them. Personality (according to more than 55% of the respondents to an Ontario Medical Association survey) plays an important part in a good doctor's make-up.

This makes the doctor, an individual either loved or feared — according to the circumstances — and projects him onto centre stage. How do we quantify the quality which relates to skill and is by far the most important criterion for selecting a doctor? This criterion reflects a point of view which doggedly persists, in spite of technological progress — the point of view of a public which has evolved from the status of "the needy in distress treated out of charity" to "the care consumer with a right to health".

At the same time, hospitals have followed a parallel evolution and have progressed from charity centres with evocative names such as "Hope" and "Mercy" to care centres, university

medical centres, and community health centres.

Finally, the Sisters of Charity who devoted themselves gratuitously to the sickbed, seeking thus their ultimate salvation in the hereafter, have become paid nurses or nurses' aides.

This transformation, made necessary by economic and social advances, has begun to form a preponderant part of national budgets at the demand of a public seeking, with justification, the "primum vivere": to escape the afflictions of illness.

Politicians have taken advantage of this exceptional political springboard and promise services now considered indispensable; they have neglected however to calculate the costs objectively and to tell taxpayers the price they will have to pay. Between the administration and the taxpaying care consumer the doctor is suddenly in the position of an intermediary, of a distributor, without any real control. For in practice, on a day to day basis, we realize that it is the consumer and therefore the public who is pressing for services, while the doctor has no way of controlling the momentum.

Let us take an example: a man who has fears about his health, seeks medical advice. The physical examination reveals nothing significant. To assuage misgivings the patient insists on para-clinical examinations — a certain number are indicated in any case on a